recognise the problem and consequent lack of treatment might aggravate disability in survivors.

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Struggling with malpractice and medical defence subscriptions

SIR,—Several correspondents on the issue of medical defence subscriptions (12 September, p 666) suggest that health authorities should bear the cost on the grounds that it is common practice for employers in industry to take out insurance for their workers.

Such a move will protect hospital doctors from the burden of rising professional indemnity subscriptions. This practice may, however, cause problems. Currently, the defence organisations offer protection not only against claims for negligence from patients but also against actions initiated by the employing authorities on matters related to contractual obligations or by the General Medical Council's disciplinary committees. If the employing authorities pay the defence subscriptions a conflict of interests may arise in defending the doctor against actions initiated by the employer.

As costs of negligence rise defence societies will probably be under pressure to limit or withdraw their support of individual members in cases relating to contractual commitment of professional conduct, especially where negligence to a patient is not in question. In many such instances failure to defend the member successfully will not result in financial losses to the defence organisations. I believe that if employing authorities take over payment of defence subscriptions it is imperative to have separate indemnity dealing solely with problems in disputes entailing the employing authority or the General Medical Council. Subscription for this important protection should be paid by individual members.

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Reviewing RAWP

SIR,—Mr N B Mays (19 September, p 703) calls for greater empirical evidence on whether patients in "socially deprived" areas stay in hospital longer for the same case mix than those in "non-deprived" areas in order to assess the need for an allowance for deprivation in National Health Service resource allocation formulas.

Simple observations of a correlation do not, however, imply causation. As a consequence, enhancing the provision of resources in areas observed to have atypically long lengths of stay generates perverse incentives, encouraging longer lengths of stay in all areas to substantiate further additions to existing allocations, and hence undermines the fundamental principle of a RAWP type formula. The results of a recent comparison of activity between Sheffield and West Lambeth health authorities suggested that observations of longer lengths of stay in inner London districts are less to do with the relative deprivation of the population and more concerned with managerial practices and the efficiency of performance of the particular districts.[1]

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1 George SL, Pitt FA, Watts M. Impact of cuts in acute beds on services for patients. *Br Med J* 1987;294:969.

Determining the incidence of HIV infection

SIR,—The debate surrounding the determination of the incidence of infection with the human immunodeficiency virus (HIV) in the general population in Britain has so far failed to identify an ethically acceptable programme. The continuing need for some system of monitoring HIV seroprevalence, however, cannot be ignored. Indeed, the World Health Organisation emphasises, in its special programme on the acquired immune deficiency syndrome (AIDS), that national AIDS programmes should include the establishment of AIDS and HIV surveillance.[1]

A random sample for whom HIV seropositivity would be of least personal impact would be those killed in road traffic accidents each year (5000 in England and Wales[2]). While the results of such a monitoring scheme would need to be adjusted to reflect the British population, it is noteworthy that the age distribution of people who die in road traffic accidents is similar to the age distribution of people who are sexually active. Furthermore, details of age, sex, and social class would be readily available without the complications that obtaining such details during a random study of HIV seroprevalence among hospital admissions would entail.

Random and anonymous studies all suffer from the limitation that risk group data are inaccessible, a failing noted by the Social Services Committee.[3] The availability of data on social class and geographical locality for those killed in road traffic accidents, however, encourages the review of demographic influences on the spread of HIV, an approach which may outlast the current reliance on risk group classification and which is in line with the World Health Organisation's global strategy.

The current estimate of HIV infection in Britain (30 000-100 000) would be reflected by 3-10 people infected with HIV among those killed in road traffic accidents each year, given a geographically similar distribution of deaths in such accidents and infection with HIV. In fact, because of the preponderance of deaths in road traffic accidents occurring in the sexually active age range there would be a positive bias towards seropositivity for HIV. Such a bias would be neutralised by normalisation of the data but would tend to improve the statistical reliability by increasing the numbers counted. The statistical confidence for one year for Britain would allow no better resolution than the current guesswork. Over time and if the approach were broadened—for instance, to Europe—the study would become more statistically powerful. In any event, it is in the trends of infection that the really crucial pointers for the future lie.

While ethical dilemmas about informing next of kin of positive results would inevitably arise, with the current demand for transplantable organs much of the HIV testing would have been carried out anyway. Thus the HIV state of the British population might be assessed with minimal intrusion and cost to individuals or to society.

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1 World Health Organisation. *Special programme on AIDS. Strategies and structure, projected needs*. Geneva: World Health Organisation, 1987: 5, 9, 14.
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Doctors against nuclear war in Turkey

SIR,—As community physicians we are concerned for Turkish colleagues who currently face government oppression resulting from their wish to publicise the BMA reports on the medical effects of nuclear war.[1,2] Last May these doctors and health workers applied for government permission to form a group opposed to nuclear war but their request was refused on the grounds that they might alarm the public and that they should leave the issue to experts—namely, the Atomic Energy Authority and the Civil Defence Department of the Ministry of the Interior.[1]

Government refusal to recognise this medical group means that Turkey is unique in having prevented its doctors and health workers from becoming affiliates of the Nobel prizewinning International Physicians for the Prevention of Nuclear War (IPPNW). With Albania and Yugoslavia, Turkey is one of only three European countries without affiliate membership of IPPNW, to which more that 50 countries now belong.

A second consequence of government refusal to register Doctors Against Nuclear War is that members of this 60 strong group face the penalties of belonging to an illegal organisation. In Turkey punishment for opposing the government or its regulations can be severe. A number of doctors who opposed increased government control over the universities have been dismissed from their posts without warning.[4] Some have also had their passports withdrawn and have been told they may never work again for a state university or for the state health service. Even more disturbing is the fact that doctors in Turkey, including Dr Erdal Atabek, a past president of the Turkish Medical Association, have been imprisoned. Dr Atabek was imprisoned for membership of the Turkish Peace Association, a multiprofessional group, which existed to support détente and multilateral disarmament. In so far as Turkey is a member of NATO, this abuse of human rights makes a mockery of NATO's claim to defend democratic rights, including that of peaceful dissent.

Letters have been received from the community physician secretary of Doctors Against Nuclear War and also from the secretary general of the Turkish Medical Association asking for our support. We therefore urge the BMA to press for the denial of the European Community membership that Turkey requests until her deplorable human rights record improves.

We also ask individual colleagues to send letters of protest to both their United Kingdom and their European MPs, and to invite Turkish physician members of Doctors Against Nuclear War to professional conferences in Britain as a means of pressing for the return of their passports. We would be glad to supply details to anyone prepared to help in this or any other way.

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3 Reuters' report. *Guardian* 1987;May 2.
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Disseminated cholesterol embolism presenting as neuromyelitis optica

SIR,—Dr Michel Goldman and coauthors (19 September, p 697) claim to be the first to describe neuromyelitis optica in association with cholesterol emboli. However, although they offer both clinical and pathological evidence for disease of the spinal cord, they give no proof that their patient ever suffered from optic neuritis.

They mention an episode of transient visual loss in the left eye six months previously which they say had been "attributed" to optic neuritis. There are no clinical details relating to this one episode on which the diagnosis appears to have been based, and it is not even clear whether the patient had been examined at the time or whether the conclusions had been made in retrospect on history alone. The only ocular findings presented in the paper were that "funduscopic examination yielded normal results" at the time of admission and that visual evoked responses showed increased latency on the left side.

There are several causes of monocular transient visual loss,[1] some of which are compatible with a normal fundal appearance. In this patient, for example, microembolisation of the retinal artery would be a possibility. The only evidence for a past optic neuritis appears to be a delayed visual evoked potential. As this finding is known not to be specific for optic neuritis,[2-5] it would be valuable to know the magnitude of the delay and whether other conditions known to cause such a delay had been excluded. The presence of demyelination of the optic chiasm, which is described in this report, could in itself be responsible for asymmetrical responses.

Although this comes under the heading of short reports, the authors should give more information about their ocular findings before they can convince the reader that they are indeed describing an optic neuritis in association with spinal cord lesions.

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5 Bresnick GH. Diabetic retinopathy viewed as a neurosensory disorder. *Arch Ophthalmol* 1986;**104**:989-90.

AUTHORS' REPLY—As indicated in our case report, the ophthalmological symptoms appeared six months before the spinal lesion, and the presumptive diagnosis of optic neuritis was made in another hospital. The demyelination of the optic chiasma observed at necropsy confirmed that the optic tract was implicated in the pathological process. The term "neuromyelitis optica" was used to describe the clinical association of optic neuropathy with subacute transverse myelopathy. We did not suggest that one or the other lesion resulted from the inflammatory process of classical "optic neuritis" or "transverse myelitis." On the contrary, the ischaemic origin of the spinal lesion was clearly documented at necropsy and embolisation was probably also the cause of an "anterior ischaemic optic neuritis."[1]

Cholesterol microemboli have been previously reported to mimic autoimmune or inflammatory diseases such as polyarteritis nodosa,[2] polymyositis,[3] or crescentic glomerulonephritis.[4] The aim of our paper was essentially to point out that cholesterol embolisation should also be considered in the differential diagnosis of neuromyelitis optica viewed as a clinical syndrome.

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Emotional distress in house officers

SIR,—Ms Jenny Firth-Cozens found that preregistration house officers in teaching hospitals were subject to more stress and more depression than those in non-teaching hospitals (29 August 1987, p 533). My first postregistration position was at the Royal Hallamshire Hospital, one of the two main teaching hospitals in Sheffield. I concluded that, in addition to those outlined by Ms Firth-Cozens, two factors were responsible for much of the stress.

Firstly, the building is a tower block with two wards on each floor. Frequently these are wards belonging to completely different specialties—for instance, urology and general medicine. This effectively isolates the junior medical staff in one ward and denies them contact with their fellows on different firms. Although this form of isolation is now widely recognised as a major problem in residential tower blocks, it seems to have been ignored in hospital design.

Secondly, because of a lack of accommodation, the Sheffield Health Authority insisted that all postregistration positions should be classed as nonresident. This meant that senior house officers and registrars were not provided with free accommodation, nor was accommodation available within the hospital. In addition, all junior doctors were instructed that patients who had been seen by a given consultant within the past year were to be reviewed by that consultant's team if they required readmission, regardless of whose team was on duty to admit patients. This further isolated the preregistration houseman, who could be called down to the casualty department to assess and admit a patient, whom he might never have seen before and knowing that if he required advice he would have to call in his senior house officer or registrar from home. There was always a postregistration physician resident for after hours duties, but his main responsibilities were to the admitting team, and he was not expected to help with patients previously admitted under another consultant. The problem on the surgical side was even worse, since the duty surgical registrar was not required to be resident. This arrangement was in direct contravention of the agreement between the British Medical Association and the Department of Health and Social Security on conditions of accommodation and service for junior medical staff. Nevertheless, a court case brought by the British Medical Association proved the contract of employment to be legal and as far as I am aware this state of affairs still exists.

What is required is a radical and logical rearrangement of the working practice of the hospital. A concerted effort must also be made to reverse the health authority's position on nonresident senior house officer and registrar positions. It is not enough simply to support a psychological study into stress in preregistration housemen, although this is a solution of which Sir Humphrey Appleby would be proud.

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Sabbaticals and practice agreements

SIR,—Dr Ian Tait discusses briefly the fundamental problem of convincing your partners of the need (sic) for you to take a sabbatical (12 September, p 644).

The success of any arrangement may depend on it being flexible enough for every partner to find the idea appealing. Their personal circumstances may constrain what they can actually do, so damping their enthusiasm. For example, one partner may have young children or be committed heavily to private education, and the idea of extra holiday may be more attractive than three months' absence from the practice.

We started having sabbaticals in 1970 and with four partners have evolved the following system. Each partner in turn is entitled to an extra eight weeks' paid leave every fourth year, which if taken with four weeks' annual leave and one week of study leave means that he or she can escape to pastures new for a total of three months.

To avoid burdening the partners who remain in residence with too much extra work a locum is employed for eight weeks at the expense of the absent partner. The cost to him may be reduced by finding paid work abroad or "once in a lifetime" by applying to the DHSS for study leave.

So, roughly every four years, as ideas and circumstances change we renegotiate the details such as whether one partner can take two weeks as extra holiday every year instead of the eight weeks every fourth year and whether the practice or the individual partner pays for the locum.

This flexible system has allowed study leaves to be taken and interesting jobs done in places as far apart as Kenya and Brunei. It has been most stimulating and the absence of a partner for three months soon settles down into a routine. Sabbaticals are hard work to organise but well worth the effort if a formula can be devised that appeals equally to all partners.

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Is the tube in the trachea?

SIR,—Dr John Kerr's leading article (15 August, p 400) and the subsequent correspondence (19 September, p 723; 10 October, p 926) on endotracheal intubation have concentrated on technology and neglected psychology. The tense situation which develops when intubation is very difficult but essential leads to a great reluctance to remove a tube that just might be in the right place—as indicated by equivocal chest inflation and breath sounds—especially when the patient's